60th Med Gp Travis AFB CA 94535

Authorization for Release of Medical or Dental Information from a Non-Military Treatment Provider

(This form is subject to the Privacy Act of 1974 – Use Blanket PAS-DD Form 2005)

Patient Data

Full Name of Patient (Last, First, Middle) _____

Date of Birth (MM/DD/YYYY) _____ Patient's SSN _____

Street Address _____

City/State/ZIP _____ Civ Med Treatment #: _____

Home Phone ( ) _____ Work ( ) _____

Dates of Treatment: FROM Date _____ TO Date _____

Type of Treatment: ☐ Outpatient ☐ Inpatient ☐ ADAPT ☐ Family Advocacy ☐ Dental

Disclosure

I authorize the following healthcare provider to release my patient information to the 60th Medical Group at Travis AFB:

Provider: _____

Street Address: _____

City/State/ZIP: _____

Phone: _____ FAX: _____

Return copy of release with documents to facilitate identifying patients receiving care at our facility under a different name or patient identification/beneficiary status.

Voice telephone:
(707) 423-5353/5352/5359

The copies should be mailed to:
60th MDSS/SGST
Attn: Outpatient Records
101 Bodin Circle
Travis AFB CA 94535-1825

Fax copies to (secure line):
(707) 423-5272 or 423-5055

Reason for Request / Use of Medical Information:

☐ Continuation of Medical Care ☐ Legal ☐ School ☐ Insurance
☐ Personal Use ☐ Other (specify): _____

Is the information being used for any pending or contemplated litigation*? ☐ Yes ☐ No

* If litigation is pending or being contemplated, request for copies are sent to the Medical Law Consultant for review according to AFI 51-501 and AFI 51-502.

Information to be released: Check the box and initial or sign to specify type of medical information to be released.

☐ Medical Information _____ (patient's initials)
☐ Mental Health Information _____ (patient's signature)
☐ Family Advocacy Information _____ (patient's signature)
☐ Drug/Alcohol Information _____ (patient's signature)
☐ AIDS/HIV Information _____ (patient's signature)
☐ Specified Medical Information _____ (patient's initials)

_____

If patient receives military medical care under dependent status:	Sponsor's Name	Sponsor's SSN

Release Authorization

I understand that:

a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMC Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.

b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would not longer be protected.

c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR § 164.524.

d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.

I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

This authorization shall become effective immediately and shall remain in effect until the release of medical information is completed or until date specified: _____

This date shall not exceed one year.

_____ _____

Signature of Patient / Parent* / Legal Representative** Date (MM/DD/YYYY)

_____

Relationship to Patient

* For dependent children, parents may sign except when the record is marked that a minor has consented to his/her own care. In this situation the record will not be released to the parent.

** For deceased patients, the next of kin must sign and furnish proof of death.

For Staff Use Only

(To be completed only upon receipt of written revocation)

☐ Authorization Revoked Reason for Revocation: _____

_____ _____

Revocation Completed By Date (MM/DD/YYYY)